STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 PONTIAC AVE, BLDG. 69-1
CRANSTON, RI 02920

IN RE: Blue Cross & Blue Shield of Rhode Island Subscription Rates for Class DIR	:	No. RH-2010-01
(Filed November 20, 2009)	:	

I.
TRAVEL

This matter came to be heard before the Office of the Health Insurance Commissioner ("OHIC") as a result of a rate filing received by OHIC on November 20, 2009 from Blue Cross & Blue Shield of Rhode Island ("Blue Cross") for its Direct Pay products ("the Filing"). The Filing requests average rate increases of 10.2% for approximately 13,900 Direct Pay subscribers to be effective April 1, 2010. In addition, Blue Cross proposed changes to certain Direct Pay products, including increases in deductible amounts and the use of age-based rating for its Basic (Pool I) subscribers.

The Filing was made pursuant to R.I. Gen. Laws §§ 27-19-6 and 27-20-6. The hearing is a contested case under the Administrative Procedures Act. R.I. Gen. Laws § 42-35-9.[1] OHIC is not a party to the case. The parties to the case are the filer, Blue Cross, and the Attorney General. R.I. Gen. Laws § 27-36-1.

Hearings were convened on January 19, 2010 and on January 26, 2010. Prior to the commencement of in-person testimony, Blue Cross and the Attorney General announced that they had entered into a stipulation of settlement that would set the rate increase at 9.5%. As a result, no in-person testimony was offered by the parties.

[1] A rate hearing held pursuant to R.I. Gen. Laws §§ 27-19-6 and 27-20-6 is a contested case under the Administrative Procedures Act. R.I. Gen. Laws § 42-35-1(3) (definition of a contested case).

Because the parties have entered into a stipulation of settlement, I have no choice but to recommend that the Commissioner enter an order accepting the stipulation of settlement. The stipulation of settlement effectively forecloses further review of the matter.

II.
JURISDICTION

OHIC has jurisdiction in this matter pursuant to R.I. Gen. Laws §§ 27-19-6, 27-20-6, and 42-14.5-1 *et seq*. The hearing was conducted in accordance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq*.

III.
FINDINGS OF FACT

1. On November 20, 2009, Blue Cross filed for a rate increase for Direct Pay subscribers. The rates now in effect have been in place since April 1, 2008.

2. The Filing requests new rates with an average increase of 10.2% for the billing cycles commencing April 1, 2010. The Filing also proposes benefit changes, rate structure changes and a new product. Those changes include:

   a. An increase in the deductible for the HealthMate Coast-to-Coast Direct Plan 400/800 from $400 per individual and $800 per family to $500 per individual and $1000 per family;
   b. A name change for the HealthMate Coast-to-Coast Direct Plan 400/800 product (the new product will be named HealthMate Coast-to-Coast Direct Plan 500/1000);
   c. An increase in the coinsurance for the HealthMate Coast-to-Coast Direct Plan 500/1000 product to 20% after the deductible has been met;
   d. The imposition of flat dollar prescription drug co-payments for the HSA eligible products after the deductible has been satisfied; and
   e. A new rate structure for Basic (Pool I) that varies rates by age.

(Blue Cross Exhibit 1)

3. The Filing also proposes a new product, HealthMate Coast-to-Coast Direct Plan 1000/2000. (Blue Cross Exhibit 1)

4. In accordance with the provisions of R.I. Gen. Laws §§ 27-19-6 and 27-20-6, the Health Insurance Commissioner designated John Aloysius Cogan Jr. as hearing officer in this matter.

5. The Filing was advertised pursuant to R.I. Gen. Laws §§ 27-19-6 and 27-20-6 on January 6, 2010 in *The Providence Journal*, and public hearings were scheduled for January 16 and January 26, 2010. (Blue Cross Exhibit 10)

6. Prior to the hearings, OHIC solicited written public comment. OHIC received approximately 103 letters and emails related to the Filing. Written public comment unanimously opposed the proposed rate increase.

7. On January 19, 2010, the first two sessions of the public hearing were held at 10 am and 6 pm. The first two sessions were convened exclusively to receive in-person public comment. A third session of the public hearing was held on January 26, 2010 at 9:30 am. The third session was convened to receive in-person public comment and in-person testimony of witnesses for Blue Cross and the Attorney General.

8. Present at all three sessions were the hearing officer, Genevieve M. Martin, Esq. and Suzette Pintard, Esq. for the Attorney General, and Normand G. Benoit, Esq. counsel for Blue Cross.

9. Approximately 17 members of the public commented on the Filing at the various sessions. All those who offered public comment expressed opposition to the proposed rate increase. (Hearing Transcript ("Tr."), January 19, 2010 (10:00 am), at 16-49; Tr., January 19, 2010 (6:00 pm), at 16-23; Tr., January 26, 2010 (9:30 am), at 8-18.)

10. At the beginning of the third session, the Attorney General and Blue Cross announced that they had entered into a settlement stipulation with respect to the proposed rate increase and product changes. In that agreement, the Attorney General and Blue Cross agreed that the exhibits submitted by Blue Cross and the Attorney General are accurate and complete, that the exhibits should be admitted into evidence, and that their actuarial testimony was provided by experts in the field of actuarial sciences.

11. The Attorney General and Blue Cross also stipulated that there should be a rate increase of 9.5% and that the imposition of age-based rating for Basic (Pool I) subscribers is appropriate.

12. The stipulation also stated that it resolved all factual issues raised by the parties with respect to the Filing and the hearing.

13. Any conclusion of law that is also a finding of fact is hereby adopted as a finding of fact.

IV.
CONCLUSIONS OF LAW

1. OHIC has jurisdiction in this proceeding in accordance with R.I. Gen. Laws §§ 27-19-6 and 27-20-6.

2. A hearing is required in this matter by R.I. Gen. Laws §§ 27-19-6 and 27-20-6, but the Commissioner is not a party to the hearing. Instead, the Commissioner renders a decision based on the record developed at the hearing.

3. All of the procedural prerequisites for the conduct of the hearing of this matter have been complied with.

4. The Filing is complete and was submitted to OHIC in accordance with the applicable statutes and regulations pertaining thereto.

5. The parties have resolved this matter through stipulation. Unless otherwise precluded by law, the parties may dispose of a contested case at any time by stipulation. Adopt. DBR Reg. 2, Section 15(I). A resolution of this matter through stipulation is not precluded by law.

6. The parties have stipulated to a rate increase of 9.5%. The parties have also stipulated to certain changes to Blue Cross' rate structures. The stipulation has been placed into the record and provides the factual record for the hearing officer and the Commissioner.

7. The stipulation is binding on the hearing officer. *In re McBurney Law Services, Inc.*, 798 A.2d 877, 881-82 (R.I. 2002) ("A stipulation entered into with the assent of counsel and their clients, relative to an evidentiary fact or an element of a claim, is conclusive upon the parties and removes the issue from the controversy. It is no longer a question for consideration by the tribunal."); *Mild v. Rhode Island Dep't of Environmental Management*, 2004 WL 2821638 at *4 (R.I. Super. Nov. 12, 2004) (applying *McBurney* to an administrative hearing); *see also*, *Yeargin, Inc. v. Auditing Div. of Utah State Tax Com'n*, 20 P.3d 287, 292-93 (Utah 2001) (administrative tribunals are bound by stipulations between parties).[2]

8. Any finding of fact that is also a conclusion of law is hereby adopted as a conclusion of law.

[2] Both the Attorney General and Blue Cross indicated that the hearing officer was bound by the record that the parties had established through the stipulation. (Tr., January 26, 2010, at 7-8)

V.
RECOMMENDATIONS

In accordance with the Findings of Fact and Conclusions of Law set forth above, and in conformity with the stipulation of the parties, I am compelled to recommend that the Commissioner accept the stipulation of the parties and the rates and product changes agreed to by the parties in the stipulation.

John Aloysius Cogan Jr., Hearing Officer

2/2/2010

Date

ORDER AND DECISION

I, Christopher F. Koller, Health Insurance Commissioner of the State of Rhode Island, having read the Findings of Fact in this matter and having satisfied myself as to their validity, do hereby adopt and accept them. Having read the Conclusions of Law and Recommendations of the Hearing Officer, however, I hereby do not adopt and accept them.

The Hearing Officer concluded that he was bound by the stipulation of settlement between the parties. I accept the facts as presented by Blue Cross and Blue Shield of Rhode Island and the Office of the Attorney General's Office in the stipulation, however, I find that pursuant to R.I. Gen. Laws § 27-19.2-1 *et seq,* the facts as stipulated do not adequately address Blue Cross's obligations to employ pricing strategies that enhance the affordability of health care coverage. I, therefore, modify the decision as follows in order to address those affordability requirements of R.I. Gen. Laws § 27-19.2-1 *et seq.* Based on the evidence presented in the record I add the following facts to the 13 presented by the Hearing Officer:

14. Direct Pay subscribers purchase their health insurance with the benefit of neither pre-tax contributions nor employer subsidies enjoyed by other commercial insurance subscribers.
15. In pricing the Direct Pay products, Blue Cross's cost allocations to its Direct Pay line of business for certain state assessments for medical services are based on the cost of those medical services in general as a percentage of all Blue Cross insurance revenue. This percentage is then applied to Direct Pay premium to produce an estimated cost of these services for Direct Pay; see Schedule 22 of Exhibit 2, which allocates the costs of

childhood immunizations and certain Department of Human Services Administered-services to youths to the Direct Pay.

16. In pricing the Direct Pay products, Blue Cross also withholds one internal cost assessment to the Direct Pay Product, for contributions to reserves, but not others, such as the State of Rhode Island's Premium Assessment. (See Exhibit 2, Schedule 20, Column 9).

Based on the findings of facts from the Hearing Officer and the additional ones noted here, I accept the eight conclusions of law presented by the Hearing Officer and add the following:

9. Blue Cross Direct Pay Subscribers exert a preferential claim on affordability efforts because their method of financing their insurance purchases leaves them most vulnerable of all commercial insurance subscribers to medical inflation.
10. The Access Blue Program targets those least able to afford the products, but all subscribers are entitled to relief from rate increase where possible.
11. The cost allocations to Direct Pay of state assessments for medical services are not based on the historical consumption of these services by Direct Pay enrollees. Direct Pay enrollees should not be subject to the risk that estimated medical costs allocated to them are greater than the costs they actually incurred. Blue Cross can and should develop a more accurate method of allocating these costs to Direct Pay subscribers. Until it does so, these costs should not be allocated to Direct Pay products.
12. As Blue Cross has the capacity to withhold certain internal assessments to Direct Pay Subscribers – such as for contributions to reserves - and thus increase the product's affordability, it should do so for other internal assessments, specifically the State's Premium Assessment. The Premium Assessment adversely affects the affordability of

the Direct Pay product. While it is a cost to Blue Cross, like a reserves assessment, it is not a cost incurred by Direct Pay subscribers for using or administering the products.

Blue Cross is therefore, in addition to the terms of the stipulation of settlement, directed to recalculate its proposed rates based on the exclusion of the Child Immunization and CEDARR, CIS and Home Services State Assessment factors in Exhbit2, Schedule 22, and with no assessment on Direct Pay Subscribers for the State's Premium Assessment in Exhibit 2, Schedule 20.

I conclude with two more general observations. First, by virtue of recent court interpretations on the conduct of Administrative Hearings ("the Arnold Decision"), this rate hearing process leaves me unable to rely on the services of an independent actuary, familiar with Blue Cross filings across all lines of business, to assess the validity of the Blue Cross trend factor assumptions. This absence was exacerbated by the stipulation of settlement in this particular case, which resulted in a paucity of evidence arising from the hearing itself.

Second, Blue Cross continues to make real efforts both to subsidize the costs of the Direct Pay product through its Access Blue product and to improve system affordability. Neither of these is likely, though, to meet the needs of the Direct Pay subscribers who spoke forcefully about the effects of the proposed rate hikes and the underlying costs of the Direct Pay products.

Either subsidies or premium reductions are needed to make Direct Pay products significantly more affordable. Additional subsidies are a matter of public policy – they should not come from Blue Cross ratepayers in other products. Costs can be lowered by enrolling more healthy people and reducing medical expenses – which comprise over 90% of the cost of premiums in this product and are rising at seven to eight times general inflation. These are

challenges for all health insurance and go beyond simple solutions. Blue Cross must continue its efforts in this arena and promote public policy changes such as provider payment reform.

Blue Cross will continue to need to be held accountable for its Direct Pay products. But rate review alone won't make health insurance affordable. Next year with this review, we will again be faced with a bad set of choices. Health insurance reforms and subsidies are needed - particularly for low and moderate-income insurance consumers who have no employer to assist them.

ENTERED AS AN ADMINSTRATIVE ORDER OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER THIS 8th DAY OF FEBRUARY, 2010.

Christopher F. Koller
Health Insurance Commissioner

THIS DECISION CONSTITUTES A FINAL DECISION OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER PURSUANT TO RHODE ISLAND GENERAL LAWS TITLE 42, CHAPTER 35. AS SUCH, THIS DECISION MAY BE APPEALED TO THE SUPERIOR COURT SITTING IN AND FOR THE COUNTY OF PROVIDENCE WITHIN THIRTY (30) DAYS OF THE DATE OF THIS ORDER. SUCH APPEAL, IF TAKEN, MAY BE COMPLETED BY FILING A PETITION FOR REVIEW IN SAID COURT.